TUBERCULOSIS SUSPECT CASE REPORT

PATIENT_____
Last First MI

ADDRESS_____

_____

PHONE_____

BIRTH DATE:____/____/____ Sex? ? M ? F

Social Security Number:_____

IF PATIENT UNDER 18, PARENT NAME/DOB:

_____

EMPLOYER/SCHOOL:_____

INSURANCE/FUNDING:_____

? White, non-Hispanic ? Black ? AM Ind/Eskimo

? Hispanic ? Asian/Pac. Is. (specify)_____

? Other_____

REPORTED BY:_____

Phone (____)_____

Diagnosing Facility_____

Medical Record# _____

Patient hospitalized at diagnosis? ? Yes ? No

Patient currently hospitalized? ? Yes ? No

Treating Physician:_____

Address_____

_____

Phone_____

Referred to for F/U:_____MD

Address_____

_____

Phone (____)_____

Will MD be continuing care? ? Yes ? No

? Pulmonary TB ? Extrapulmonary (site)_____ Date dx: ____/____/____

Skin Test_____mm ? Negative Chest X-Ray Date:_____ ? Cavitary ? Non-Cav.

Date read_____ ? Not done Impression:_____

? Anergic Controls:_____

_____

_____

If Pulmonary, check symptoms:

? Cough ? Night sweats

? Sputum production ? Hemoptysis

? Weight loss (# of lbs.)_____

History of TB Treatment ? Yes ? No

If Yes: Where/when treated?_____

_____

If asymptomatic, reason for evaluation_____

Other medical conditions relevant to diagnosis_____

HIV Status: ? Positive ? Negative ? Unknown

Date:_____ ? Recommended ? Pending

CD4 Count_____ Date:_____

Patient's current weight_____

Psychosocial History?_____

Allergies_____

SPECIMEN NUMBER	SPECIME DATE	SPECIMEN TYPE	AFB SMEAR	AFB CULTURE

MEDICATIONS	DOSE	START DATE
ISONIAZID		
RIFAMPIN		
ETHAMBUTOL		
PYRAZINAMIDE		
PYRIDOXINE (B6)		

Lab Name/Acct. No._____

Is Directly Observed Therapy (DOT) indicated? ? Yes ? No Reason:_____

Additional Comments:_____

_____

_____

Date Reported:_____ Recorded By:_____

TUBERCULOSIS CONTROL

Reporting of all patients with confirmed or suspect tuberculosis (TB) is mandated by state Health and Safety Codes Div. 4, Chapter 5 and Admin, Codes, Title 17, Chapter 4, Section 2500 and must be done within **one day of diagnosis.**

WHY DO YOU REPORT?

Because it is the law! The health department performs many vital functions to ensure public health and safety, including case management, contact follow-up, assessment of compliance with treatment and appointments, and directly observed therapy (DOT). The TB Control staff will also assist in facilitating timely and appropriate discharge planning. **Since January 1, 1994, state law mandates that all TB patients have a health department-approved discharge plan, *prior* to discharge.**

WHO MUST REPORT?

Anyone aware of a patient suspected to have, or confirmed with, active TB.

WHEN DO YOU REPORT?

A) When active TB is one of the primary differential diagnoses. This often occurs when:
   1. signs and symptoms of TB are present, and/or
   2. the patient has an abnormal chest x-ray consistent with TB, and/or
   3. the patient is placed on multidrug therapy for active TB or

B) When specimen smears are positive for acid fast bacilli (AFB).

C) When the patient has a positive *M. tuberculosis* or *M. bovis* culture.

HOW DO YOU REPORT?

The form on the other side is to be completed **in its entirety** and submitted to the health department. TB Control staff will review this form and may return a call to the physician as needed.

By phone: (619) 692-8610

By pager: (619) 526-1878 (weekdays 8:00 a.m.-5:00 p.m., weekends/holidays 8:00 a.m.-5:00 p.m.)

By FAX: (619) 692-5516

This form, when submitted to TB Control, fulfills the legal requirement for reporting. The process for discharge or transfer approval necessitates a different form. Please call (619) 692-8610 for further information about discharge care plan submission/approval.